

# PERSONAL INFORMATION

(PLEASE, CAPITAL PRINT)



INVOICE #  DATE:

FIRST NAME:

LAST NAME:

BIRTH DATE:  DEPARTURE DATE:

ADDRESS:

POSTAL CODE:  CITY:

STATE/PROVINCE/REGION:  COUNTRY:

E-MAIL:

PHONE N°:  FAX N°:

PASSPORT #:

HOTEL:  ROOM N°:

EMERGENCY CONTACT

Olympus Dive Center  
Morehead City, NC

## To be filled out by DRESSEL DIVERS CLUB:

DL:

Certification  Organization

Certification #  Insurance Policy #

# of Dives  Date of last Dive #  /  /

Date of Payment  /  /  Invoice #

Dive	Date	Dive Site	Comments
1			
2			
3			
4			
5			
6			

Dive	Date	Dive Site	Comments
7			
8			
9			
10			
11			
12			
13			
14			
15			
16			



If you need more space write at the back of this page.

## MEDICAL STATEMENT Participant Record (Confidential Information)

### Please read carefully before signing.

This is a statement in which you are informed of some potential risks involved in scuba diving and of the conduct required of you during the scuba training program. Your signature on this statement is required for you to participate in the scuba training program offered by **DRESSEL DIVERS CLUB INTERNATIONAL** (also legally known as **MANTA DIVERS S.A.** in the Dominican Republic, and/or **BLUE TANG DIVERS, S.R.L.** also in the Dominican Republic, and/or **CLUB DE BUCEO PLAYA S.A. DE C.V.** in Mexico, and/or **ACUATICA MAYA S.A. DE C.V.** also in Mexico, and/or **ACUATICALITIBU S de RL DE C.V.** also in Mexico, and/or **SPORTS & DIVER CLUB LTD.** in Jamaica).

**Read this statement prior to signing it.** You must complete this Medical Statement, which includes the medical questionnaire section, to enroll in the scuba training program.

**If you are a minor,** you must have this Statement signed by a parent or guardian. Diving is an exciting and demanding activity. When performed correctly, applying correct techniques, it is relatively safe. When established safety procedures are not followed, however, there are increased risks.

### Divers Medical Questionnaire To the Participant:

The purpose of this Medical Questionnaire is to find out if you should be exam-ined by your doctor before participating in recreational diver training. A positive response to a question does not necessarily disqualify you from diving. A positive response means that there is a preexisting condition that may affect your safety while diving and you must seek the advice of your physician prior to engaging in dive activities.

**To scuba dive safely,** you should not be extremely overweight or out of condition. Diving can be strenuous under certain conditions. Your respiratory and circulatory systems must be in good health. All body air spaces must be normal and healthy.

A person with coronary disease, a current cold or congestion, epilepsy, a severe medical problem or who is under the influence of alcohol or drugs should not dive. If you have asthma, heart disease, other chronic medical conditions or you are taking medications on a regular basis, you should consult your doctor and the instructor before participating in this program, and on a regular basis thereafter upon completion. You will also learn from the instructor the important safety rules regarding breathing and equalization while scuba diving. Improper use of scuba equipment can result in serious injury. You must be thoroughly instructed in its use under direct supervision of a qualified instructor to use it safely.

If you have any additional questions regarding this Medical Statement or the Medical Questionnaire section, review them with your instructor before signing.

Please answer the following questions on your past or present medical history with a **YES** or **NO**. If you are not sure, answer **YES**. If any of these items apply to you, we must request that you consult with a physician prior to participating in scuba diving. Your instructor will supply you with an RSTC Medical Statement and Guidelines for Recreational Scuba Diver's Physical Examination to take to your physician.

1. I have had problems with my lungs, breathing, heart and/or blood affecting my normal physical or mental performance.	Yes <input type="checkbox"/> Go to Box A	No <input type="checkbox"/>
2. I am over 45 years of age.	Yes <input type="checkbox"/> Go to Box B	No <input type="checkbox"/>
3. I struggle to perform moderate exercise (for example, walk 1.6 kilometer/one mile in 14 minutes or swim 200 meters/yards without resting), OR, I have been unable to participate in a normal physical activity due to fitness or health reasons within the past 12 months.	Yes <input type="checkbox"/> *	No <input type="checkbox"/>
4. I have had problems with my eyes, ears, or nasal passages/sinuses.	Yes <input type="checkbox"/> Go to Box C	No <input type="checkbox"/>
5. I have had surgery within the last 12 months, OR I have ongoing problems related to past surgery.	Yes <input type="checkbox"/> *	No <input type="checkbox"/>
6. I have lost consciousness, had migraine headaches, seizures, stroke, significant head injury, or suffer from persistent neurologic injury or disease.	Yes <input type="checkbox"/> Go to Box D	No <input type="checkbox"/>
7. I am currently undergoing treatment (or have required treatment within the last five years) for psychological problems, personality disorder, panic attacks, or an addiction to drugs or alcohol; or, I have been diagnosed with a learning or developmental disability.	Yes <input type="checkbox"/> Go to Box E	No <input type="checkbox"/>
8. I have had back problems, hernia, ulcers, or diabetes.	Yes <input type="checkbox"/> Go to Box F	No <input type="checkbox"/>
9. I have had stomach or intestine problems, including recent diarrhea.	Yes <input type="checkbox"/> Go to Box G	No <input type="checkbox"/>
10. I am taking prescription medications (with the exception of birth control or anti-malarial drugs other than mefloquine (Lariam).	Yes <input type="checkbox"/> *	No <input type="checkbox"/>

\*For all other questions answered **YES** you will be given a supplemental form to complete.

The information I have provided about my medical history is accurate to the best of my knowledge.  
I agree to accept responsibility for omissions regarding my failure to disclose any existing or past health condition.

Signature	Date (Day / Month / Year)	Signature of Parent or Guardian	Date (Day / Month / Year)
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## LIABILITY RELEASE AND ASSUMPTION OF RISK AGREEMENT

### Please read carefully and fill in all blanks before signing.

I, \_\_\_\_\_, hereby affirm that I am aware that skin and scuba diving have inherent risks which may result in serious injury or death. *(Participant Name)*

I understand that diving with compressed air involves certain inherent risks: including but not limited to decompression sickness, embolism or other hyperbaric/air expansion injury that require treatment in a recompression chamber. I further understand that the open water diving trips which are necessary for training and for certification may be conducted at a site that is remote, either by time or distance or both, from such a recompression chamber. I still choose to proceed with such instructional dives in spite of the possible absence of a recompression chamber in proximity to the dive site.

I understand and agree that neither my instructor(s), \_\_\_\_\_, nor **DRESSEL DIVERS CLUB INTERNATIONAL** (also legally known as **MANTA DIVERS S.A.** in the Dominican Republic, and/or **BLUE TANG DIVERS, S.R.L.** also in the Dominican Republic, and/or **CLUB DE BUCEO PLAYA S.A. DE C.V.** in Mexico, and/or **ACUATICA MAYA S.A. DE C.V.** also in Mexico, and/or **ACUATICA LITIBU S de RL de C.V.** also in Mexico, and/or **SPORTS & DIVER CLUB LTD.** in Jamaica), nor **INTERNATIONAL PADI, INC.**, and/or **ITI HOLDINGS, LLC** (also known as SDI) nor its affiliate and subsidiary corporations, nor any of their respective employees, officers, agents, contractors or assigns (hereinafter referred to as "Released Parties") may be held liable or responsible in any way for any injury, death or other damages to me, my family, estate, heirs or assigns that may occur as a result of my participation in this diving program or as a result of the negligence of any party, including the Released Parties, whether passive or active.

I acknowledge and agree that I have contracted the services referred by this receipt exclusively with Dressel Divers International, therefore I exclude any other person or entity from any legal liability directly or related to such activities. Which I do so under my own will, risk, and under the direct and exclusive dependence of Dressel Divers Club International.

In consideration of being allowed to participate in this course I hereby personally assume all risks of this course, whether foreseen or unforeseen, that may befall me while I am a participant in this course including, but not limited to, the academics, confined water and/or open water activities.

I further release, exempt and hold harmless said program and Released Parties from any claim or lawsuit by me, my family, estate, heirs or assigns, arising out of my enrollment and participation in this program including both claims arising during the program or after I receive my certification.

I also understand that skin diving and scuba diving are physically strenuous activities and that I will be exerting myself during this program, and that if I am injured as a result of heart attack, panic, hyperventilation, drowning or any other cause, that I expressly assume the risk of said injuries and that I will not hold the Released Parties responsible for the same.

I further state that I am of lawful age and legally competent to sign this liability release, or that I have acquired the written consent of my parent or guardian. I understand the terms herein are contractual and not a mere recital, and that I have signed this Agreement of my own free act and with the knowledge that I hereby agree to waive my legal rights. I further agree that if any provision of this Agreement is found to be unenforceable or invalid, that provision shall be severed from this Agreement. The remainder of this Agreement will then be construed as though the un-enforceable provision had never been contained herein.

I understand and agree that I am not only giving up my right to sue the Released Parties but also any rights my heirs, assigns, or beneficiaries may have to sue the Released Parties resulting from my death. I further represent I have the authority to do so and that my heirs, assigns, or beneficiaries will be stopped from claiming otherwise because of my representations to the Released Parties.

I, \_\_\_\_\_, BY THIS INSTRUMENT AGREE TO EXEMPT AND RELEASE MY INSTRUCTOR(S), *(Participant Name)*

\_\_\_\_\_, and **DRESSEL DIVERS CLUB INTERNATIONAL** (also legally known as **MANTA DIVERS S.A.** in the Dominican Republic, and/or **BLUE TANG DIVERS, S.R.L.** also in the Dominican Republic, and/or **CLUB DE BUCEO PLAYA S.A. DE C.V.** in Mexico, and/or **ACUATICA MAYA S.A. DE C.V.** also in Mexico, and/or **ACUATICA LITIBU S de RL de C.V.** and/or **SPORTS & DIVER CLUB LTD.** in Jamaica), **INTERNATIONAL PADI, INC.**, and/or **ITI HOLDINGS, LLC** (also known as SDI) AND ALL RELATED ENTITIES AS DEFINED ABOVE, FROM ALL LIABILITY OR RESPONSIBILITY WHATSOEVER FOR PERSONAL INJURY, PROPERTY DAMAGE OR WRONGFUL DEATH HOWEVER CAUSED, INCLUDING BUT NOT LIMITED TO THE NEGLIGENCE OF THE RELEASED PARTIES, WHETHER PASSIVE OR ACTIVE.

I HAVE FULLY INFORMED MYSELF AND MY HEIRS OF THE CONTENTS OF THIS LIABILITY RELEASE AND ASSUMPTION OF RISK AGREEMENT BY READING IT BEFORE I SIGNED IT ON BEHALF OF MYSELF AND MY HEIRS.

IN CASE OF DISPUTE AND IN AGREEMENT WITH THIS DISCLAIMER, FOR ALL MATTERS RELATED TO ITS INTERPRETATION, PERFORMANCE, COMPLIANCE, EXECUTION OF THE CONTRACTED ACTIVITIES AND DURING ITS DEVELOPMENT, I AM EXPRESSLY SUBJECT TO THE LAWS AND JURISDICTION OF THE COUNTRY WHERE THIS DOCUMENT HAS BEEN SIGNED, AND EXPRESSLY RENOUNCE ANY OTHER JURISDICTION OR FORUM THAT COULD CORRESPOND TO ME DUE TO MY PRESENT OR FUTURE ADDRESS, NATIONALITY, OR FOR ANY OTHER REASON.

Participant Signature

Date (Day/Month/Year)

Signature of Parent/Guardian (where applicable)

Date (Day/Month/Year)



## Diver Medical | Participant Questionnaire Continued

<b>BOX A – I HAVE/HAVE HAD:</b>		
Chest surgery, heart surgery, heart valve surgery, an implantable medical device (eg, stent, pacemaker, neurostimulator), pneumothorax, and/or chronic lung disease.	Yes <input type="checkbox"/> *	No <input type="checkbox"/>
Asthma, wheezing, severe allergies, hay fever or congested airways within the last 12 months that limits my physical activity/exercise.	Yes <input type="checkbox"/> *	No <input type="checkbox"/>
A problem or illness involving my heart such as: angina, chest pain on exertion, heart failure, immersion pulmonary edema, heart attack or stroke, OR am taking medication for any heart condition.	Yes <input type="checkbox"/> *	No <input type="checkbox"/>
Recurrent bronchitis and currently coughing within the past 12 months, OR have been diagnosed with emphysema.	Yes <input type="checkbox"/> *	No <input type="checkbox"/>
Symptoms affecting my lungs, breathing, heart and/or blood in the last 30 days that impair my physical or mental performance.	Yes <input type="checkbox"/> *	No <input type="checkbox"/>
<b>BOX B – I AM OVER 45 YEARS OF AGE AND:</b>		
I currently smoke or inhale nicotine by other means.	Yes <input type="checkbox"/> *	No <input type="checkbox"/>
I have a high cholesterol level.	Yes <input type="checkbox"/> *	No <input type="checkbox"/>
I have high blood pressure.	Yes <input type="checkbox"/> *	No <input type="checkbox"/>
I have had a close blood relative die suddenly or of cardiac disease or stroke before the age of 50, OR have a family history of heart disease before age 50 (including abnormal heart rhythms, coronary artery disease or cardiomyopathy).	Yes <input type="checkbox"/> *	No <input type="checkbox"/>
<b>BOX C – I HAVE/HAVE HAD:</b>		
Sinus surgery within the last 6 months.	Yes <input type="checkbox"/> *	No <input type="checkbox"/>
Ear disease or ear surgery, hearing loss, or problems with balance.	Yes <input type="checkbox"/> *	No <input type="checkbox"/>
Recurrent sinusitis within the past 12 months.	Yes <input type="checkbox"/> *	No <input type="checkbox"/>
Eye surgery within the past 3 months.	Yes <input type="checkbox"/> *	No <input type="checkbox"/>
<b>BOX D – I HAVE/HAVE HAD:</b>		
Head injury with loss of consciousness within the past 5 years.	Yes <input type="checkbox"/> *	No <input type="checkbox"/>
Persistent neurologic injury or disease.	Yes <input type="checkbox"/> *	No <input type="checkbox"/>
Recurring migraine headaches within the past 12 months, or take medications to prevent them.	Yes <input type="checkbox"/> *	No <input type="checkbox"/>
Blackouts or fainting (full/partial loss of consciousness) within the last 5 years.	Yes <input type="checkbox"/> *	No <input type="checkbox"/>
Epilepsy, seizures, or convulsions, OR take medications to prevent them.	Yes <input type="checkbox"/> *	No <input type="checkbox"/>
<b>BOX E – I HAVE/HAVE HAD:</b>		
Behavioral health, mental or psychological problems requiring medical/psychiatric treatment.	Yes <input type="checkbox"/> *	No <input type="checkbox"/>
Major depression, suicidal ideation, panic attacks, uncontrolled bipolar disorder requiring medication/psychiatric treatment.	Yes <input type="checkbox"/> *	No <input type="checkbox"/>
Been diagnosed with a mental health condition or a learning/developmental disorder that requires ongoing care or special accommodation.	Yes <input type="checkbox"/> *	No <input type="checkbox"/>
An addiction to drugs or alcohol requiring treatment within the last 5 years.	Yes <input type="checkbox"/> *	No <input type="checkbox"/>
<b>BOX F – I HAVE/HAVE HAD:</b>		
Recurrent back problems in the last 6 months that limit my everyday activity.	Yes <input type="checkbox"/> *	No <input type="checkbox"/>
Back or spinal surgery within the last 12 months.	Yes <input type="checkbox"/> *	No <input type="checkbox"/>
Diabetes, either drug or diet controlled, OR gestational diabetes within the last 12 months.	Yes <input type="checkbox"/> *	No <input type="checkbox"/>
An uncorrected hernia that limits my physical abilities.	Yes <input type="checkbox"/> *	No <input type="checkbox"/>
Active or untreated ulcers, problem wounds, or ulcer surgery within the last 6 months.	Yes <input type="checkbox"/> *	No <input type="checkbox"/>
<b>BOX G – I HAVE HAD:</b>		
Ostomy surgery and do not have medical clearance to swim or engage in physical activity.	Yes <input type="checkbox"/> *	No <input type="checkbox"/>
Dehydration requiring medical intervention within the last 7 days.	Yes <input type="checkbox"/> *	No <input type="checkbox"/>
Active or untreated stomach or intestinal ulcers or ulcer surgery within the last 6 months.	Yes <input type="checkbox"/> *	No <input type="checkbox"/>
Frequent heartburn, regurgitation, or gastroesophageal reflux disease (GERD).	Yes <input type="checkbox"/> *	No <input type="checkbox"/>
Active or uncontrolled ulcerative colitis or Crohn's disease.	Yes <input type="checkbox"/> *	No <input type="checkbox"/>
Bariatric surgery within the last 12 months.	Yes <input type="checkbox"/> *	No <input type="checkbox"/>

# Diver Medical | Medical Examiner's Evaluation Form

Participant Name	Birthdate
<hr/>	<hr/>
(Print)	Date (dd/mm/yyyy)

The above-named person requests your opinion of his/her medical suitability to participate in recreational scuba diving or freediving training or activity. Please visit [uhms.org](https://uhms.org) for medical guidance on medical conditions as they relate to diving. Review the areas relevant to your patient as part of your evaluation.

## Evaluation Result

☐ Approved – I find no conditions that I consider incompatible with recreational scuba diving or freediving.

☐ Not approved – I find conditions that I consider incompatible with recreational scuba diving or freediving.

<hr/>	<hr/>
Signature of certified medical doctor or other legally certified medical provider	Date (dd/mm/yyyy)

Medical Examiner's Name

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(Print)

Clinical Degrees/Credentials

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Clinic/Hospital

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Address

---

Phone	Email
<hr/>	<hr/>

Physician/Clinic Stamp (optional)

Created by the [Diver Medical Screen Committee](#) in association with the following bodies:

**The Undersea & Hyperbaric Medical Society**

**DAN (US)**

**DAN Europe**

**Hyperbaric Medicine Division, University of California, San Diego**